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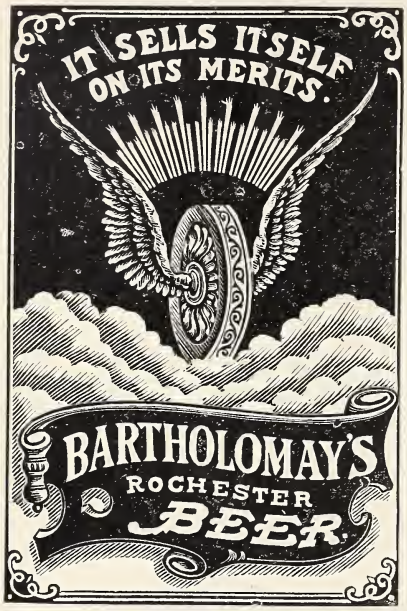

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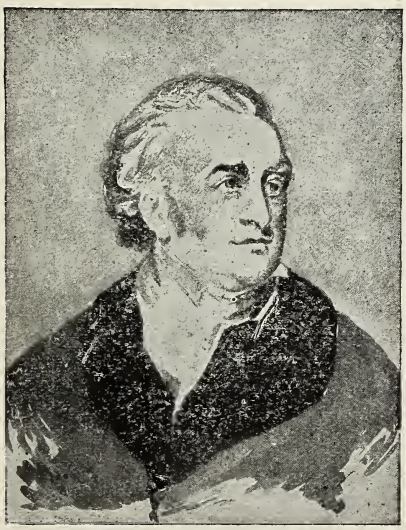

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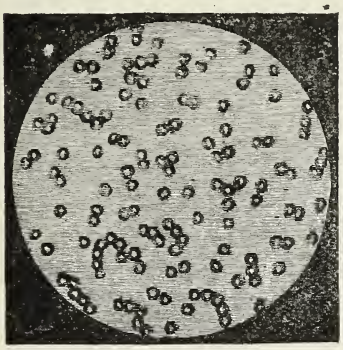

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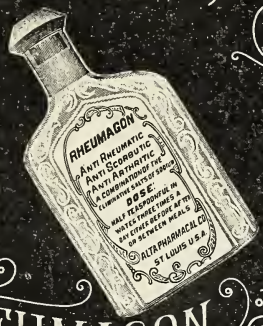

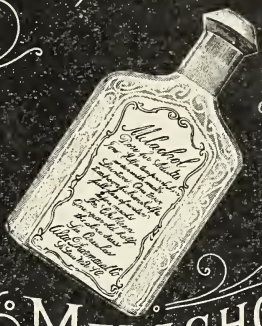

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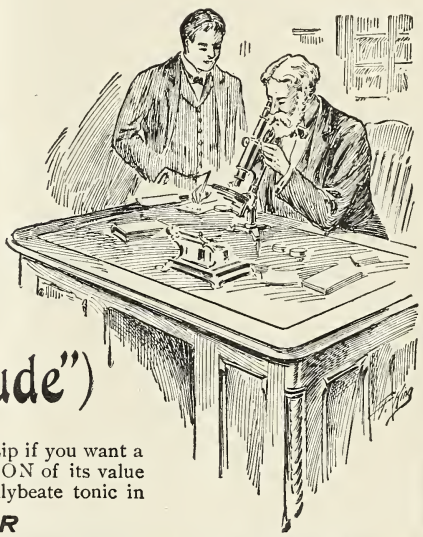

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VOL. XXXVI.—No. 20. BALTIMORE, FEBRUARY 27, 1897. WHOLE No. 831

Original Articles.

THE VALUE OF STATISTICS.

By John S. Fulton, M. D.,
Secretary of the State Board of Health of Maryland.

READ BEFORE THE CONFERENCE OF HEALTH OFFICERS HELD AT BALTIMORE, FEBRUARY 17 AND 18, 1897.

THE pursuit of scientific truth is by one means and one method. Observation is the only means, and repetition the only method. Without repeated observation is not anything known that is known. No single observation determines any truth. The first product of observation is suggestion, or conjecture; repetition transmutes the crude material first into opinion, then to conviction, and at last, perhaps, to demontration. Early in the series one may doubt the observation, at the end of the series one doubts not the observation, but the observer.

The scientific method is, therefore, essentially statistical. Indeed, statistics of one sort or another are the only ground upon which any of the business of this world has ever been successfully conducted. Each of us manages his own affairs by light of his own and others' experience, that is, by the statistical method; or else he mismanages.

Those who say what we so often hear, that statistics are misleading, mistake the passive for the active, like the belated and elated citizen who at midnight damns the keyhole for an artful dodger. Delusion is wrought, not by figures that lie, but by liars that figure.

To make a contention for the application of the statistical method to the latest, largest, and most important section of the field of practical medicine, is to engage in a work which ought to be wholly unnecessary.

Statistics opened the door to preventive medicine. In most civilized countries vital statistics have long been collected, not for any medical use, but for their great business value; and their regular, systematic record and classification not only first demonstrated the need of organized effort, but have also been of constant service in the device of means to prevent disease and death.

In England vital statistics have been collected and published since 1838, while the first report of the Medical Officer of the Privy Council appeared twenty years later. The vital statistics of Massachusetts have been collected since 1842, but the Board of Health was not created till 1869. The vital statistics of Michigan antedate the organization of the Board of Health by five years.

The commonwealth of Maryland instituted her public health organization upon indications furnished by the statistics of other communities, and yet lacks figures of her own which can justify the existence of a Board of Health. Apparently Maryland is content to be told once in ten years that her capital stock in human life has increased. She

never conducts such an inquiry for herself, nor ever asks if human life has anywhere been wasted. She collects information about the frequency, extent, localities, causes of, and defenses against fire, and a hundred or more fire insurance companies adjust their rates accordingly. The life companies do a vastly greater business, based upon statistics which do not contain a single line of Maryland figures.

There are reports upon oyster, terrapin and game, the cattle on her hills are numbered, there are treasured archives in her herd books, and the Live Stock Sanitary Board meets thrice weekly. The State Board of Health has monthly meetings, but makes no record when a Maryland mother does her duty. A practice of State Medicine which wants those things which can best direct its measures and attest its results has little kinship with the science of today. It is more closely related to the art of a century ago, so brutally characterized by Sir Astley Cooper, whom one will not quote for fear of falling into condemnation.

If it is sought to move legislation to supply such data, it must, I fear, be shown that some good will accrue to the commonwealth, other than a practical knowledge of the forces arrayed against public health. The preaching in season and out of season of hygiene is utterly futile, so long as the commonwealth is under no conviction of sin. Citizens, councils and corporations will only hear the voice of the tempest or the earthquake.

Four cases of rabies send a shudder to every fireside, and set aroar all the presses of the State; but in ten lines weekly from the City Health Department there are suppressed more and worse "'orrible and disgustin' details." If all days were dog days, rabies would not cut so wide a swath of desolation as marks the unobstructed path of measles or of whooping cough.

In 1890, measles slew 248 innocents in Baltimore, and this city has for twenty years paid tribute of about two lives a week to whooping cough.

The ever active Health Department was recently besieged with inquiry. Nearly a million people wanted to know why the water smelled badly. Did any one ask Dr. McShane whether water-borne diseases were costing us more than the usual two lives a day?

A town nourishing and cherishing 70,000 culture vats for intestinal bacteria sets up a hundred gates at railway crossings, as if by some subtle algebra, the value of life might be computed from the manner of death.

Does the medical profession of this State of Maryland appreciate the value of vital statistics? I fear not. If they did, no legislature could withstand their clamor for a law on the subject. Statistical tables are rather seldom studied by the rank and file of the craft. Ignorance of the use of this weapon must be somewhat prevalent everywhere, or we should not so often see bad theories obtain a temporary success by the aid of figures. We are learning today from the laboratories many things that might have long since been demonstrated by mortality tables. The unity of croup and diphtheria was practically shown by vital statistics years ago. In an assembly acquainted with the statistics of rabies, any person who would maintain that there is no specific disease entitled to that name would enjoy the same unenviable distinction accorded to the Rev. John Jasper, who thinks that the "Sun do move."

If this convention shall accomplish no other work, it will have served the State well if it shall unite the profession to believe and to propagate the truth that the people of Maryland have absolute need of a yearly balance sheet of life and death.

What data must vital statistics provide? From the business point of view the commonwealth has equal need to know her birth rate and death rate. From the medical standpoint, a knowledge of the places, causes and number of deaths is of first importance. Obviously the prime requisite for preventing deaths is a knowledge of the cause of death. The number of deaths assigned to each cause and each locality gives

us the needful acquaintance with the strength and position of our enemies. To know these things is the first and constant need of the sanitarian. They may not be learned once for all, must be relearned from week to week, and from year to year.

Various methods of collecting returns of death have been tried with less or more success, and it has been found that accurate results cannot be secured except by systematic registration of the facts at the time and place of their occurrence. Returns made weekly lose much of their value, monthly returns are worse, and yearly returns have little or no value. It is also clear that the facts must be recorded by an expert observer. The returns of undertakers and ministers are, and always must be, incomplete.

The only sure method of obtaining such records as may be profitably compiled and classified is based upon legislation which forbids the burial of a human body, except upon issue, from a central office, of a permit based upon a complete and accurate registration of the facts connected with the death. Such a record will embrace the name, age, race, sex, social condition, occupation, birth-place, residence, cause of death, duration of illness, with all other information which has practical interest and can properly be conveyed by the attending physician, or next of kin. The most available source of expert information is the attending physician.

Now the physician has no personal interest in the execution of such a law, and sometimes he objects to the imposition of such a tax upon his time without the offer of any compensation. I do not think that this objection is a very common nor do I consider it a very reasonable one. His is a protected industry, and the physician receives, even in this State, certain privileges and immunities which fairly compensate him for the trouble involved in the preparation of a death record. The law can, of course, not compel a physician to testify to matters of which he has no personal knowledge, such as the age and birth-place of a decedent, but under her police power, to protect life and prevent fraud, the State may exact of a physician testimony as to the cause of death.

In certain exceptional instances the responsiblity of the physician may be very great, since he is the first judge of the evidence as to whether or not the death was due to crime or negligence, or whether further inquiry is necessary. He may not be required to testify beyond what he knows, but it should be easy for him to indicate in his report what matters are of personal knowledge, and what are the results of inquiry.

It is in all cases wise, and perhaps generally necessary, to verify the death. Fraudulent reports of death are often the basis of swindling schemes.

In France, Austria and Belgium reported deaths are always subjected to verification by a physician employed and paid by the State. In England, and in our own country, the signed testimony of the attending physician secures the issue of a burial permit.

A very appreciable benefit to well qualified practitioners indirectly follows the practice of registration of deaths. The first thing which a registrar will have to inquire is, whose certificates shall be accepted. This question will not be settled in a week, nor in a year. The character of the documents presented will more and more emphasize the necessity for discrimination as to who shall and who shall not be admitted competent to testify as to the fact or cause of death. If the State can of right demand any special qualification of medical men, it must exact that they shall be fit to certify as to the cause of deaths occurring under their observation. Thus the death certificate lays the foundation for effective legislation upon medical education, and draws a very clear line between the fit and the unfit to practice medicine.

To meet the physician's want of knowledge of past history of a decedent, the death certificate should be in two parts. The first part devoted to name, age, race, sex, social condition, occupation, residence, parents' names, and place of death should be filled and signed

by the householder or next of kin. The second part should be the certificate of the attending physician, who should state that he attended the deceased from ——— to ———, last saw him alive on ———, and that he died on ——— date at ——— time, cause of death, duration of disease and complications.

The certificate thus prepared upon competent evidence, and presented at a central office, a burial permit should be issued to a legally authorized undertaker or sexton, who should be obliged to return to the central office the fact place, date and manner of burial. These regulations should have flexibility to meet certain exceptional contingencies, such as coroners' and other judicial inquiries, and deaths from contagious disease, where speedy burial is desirable.

Under such a system no penalty need be provided for failure on the part of the physician to report a death. The penalty would fall upon any person who should bury or attempt to bury a human body without a permit. A penalty should however be provided for fraudulent report, as for instance, the concealment of an infectious disease under a certificate of death from heart disease or paralysis.

This method would, if put into practice in our State, secure the registration of all the essential facts concerning ninety-five per cent. of the deaths which occur. The data so obtained, properly classified and compared, would be a useful implement in the hands of the State Board of Health.

The relation of the physician to the registration of births is not that of an expert witness. Such statistics are not of medical use and the medical man has no other interest in them than that of the average citizen. He should not be compelled to collect and return them unless he is paid for it, but having particular knowledge of the practical value of such statistics, he, more than any other citizen, should insist that they shall be exhaustively collected and exactly kept. They are of steadily increasing value both for private and public use, and their importance is most appreciated where they have been longest preserved. I suspect more pension claims are delayed and obstructed for lack of record of the marriage of parents and births of children, than by any other cause whatever.

We have statutory provision as to the "age of consent," as to responsibility for crime or misdemeanor, as to voting, as to education, as to child labor, as to descent, as to the guardian and administration, as to disabilities of minors, as to jury duty and military service, as to marriage, admission to certain professions, as to public office, etc. To meet the difficulties growing out of the absence of records, the courts admit the best "obtainable evidence." Securing the best "obtainable evidence" costs almost as much money every year as would pay the expenses of a vital statistics bureau.

The vital statistics of Chicago are confessedly very incomplete, not more than sixty per cent. of births being reported. The Registrar of Vital Statistics of Cook County furnishes a thousand copies a year of certificates of birth, which are accepted as final and conclusive evidence. The same official can also furnish a multitude of instances in which application has been made for copies of non-existent records, in default of which claims failed of adjustment, or remain yet unsettled, or were at last adjudicated after great expenditure of time, money and labor.

Most experts think it is impossible to collect statistics of sickness, believing that the compulsory notification of infectious diseases is as far as the law can carry us in that direction. To obtain the registration of infectious diseases four plans are used: First, immediate notification of the health officer by the doctor; Second, notification by the householder, or next of kin; Third, doctor to notify householder, householder to notify authorities; Fourth, both doctor and householder to notify.

The British Parliament in 1889 passed an infectious disease notification bill which contained the following provisions: "The head of the family to which

such inmate belongs; and in his default the nearest relative present in the building, or being in attendance on the patient; and in default of such relations, every person in charge of or in attendance on the patient; and in default of any such person, the occupier of the building, shall as soon as he becomes aware that the patient is suffering from an infectious disease to which the act applies, send notice thereof to the medical officer of health of the district. Every medical practitioner attending on or called on to visit the patient shall forthwith, on becoming aware that the patient is suffering from an infectious disease to which act applies, send to the medical officer of health for the district a certificate, stating the name of the patient, the situation of the building, the name of the head of the family or other person who appears to him primarily liable to formally give the notice under this act to the medical officer, and the infectious disease from which in the opinion of such medical practitioner the patient is suffering. Every person who fails to give notice or certificate as required by this section shall be liable on summary conviction in a manner provided by the summary jurisdiction acts to a fine not exceeding forty shillings ($10). The local authority shall gratuitously supply forms of certificate to any medical practitioner residing or practicing in their district who applies for the same, and shall pay to every medical practitioner for each certificate, duly sent to him, in accordance with this act, a fee of 2s. 6d. (62 cents) if the case occurs in his private practice, and of one shilling (25 cents) if the case occurs in his practice as medical officer of any public body or institution.

In Rome, physicians are supplied with a little book of coupons of which two are detached whenever a case of infectious disease is discovered. One is delivered to the "syndic" and the other to the health officer. It is thought that these two officers act as a check upon each other. The law is very effective in its operation.

Physicians in this country have a reasonable opposition to a law which inflicts a penalty upon them for failure to do that which if done will invoke the hostility of their patrons, and cannot be expected to actively controvert the narrow views of those who regard the notification of infectious disease as a violation of professional confidence.

The responsibility should go directly with the interests involved. The interest of physician and householder alike requires that early diagnosis should be made and expressed in such cases. It is one of the professional obligations of the physician that he shall notify the householder. He should, for the protection of the householder, be obliged, under penalty, to do so in writing. The householder should acknowledge the notification in writing and should, for the physician's protection, release him from responsibility for the results to the family of the presence of infection.

It is directly against his own interest for the physician to assume the responsibility of either isolation or disinfection, and it is a grave default of ordinary skill and care if he fails to advise both isolation and disinfection. He dare not testify that a case which he sees once or twice a day is isolated and he cannot afford to disinfect even if he be perchance competent to do so. In all towns and villages where a health organization exists, it should be unlawful for the practicing physician to disinfect a house. Such a prohibitory law would conserve the interests of both the profession and the public. It is enough that the doctor shall engage not to convey infection into or out of the sick-room and his patrons should not be permitted to lightly regard these extraordinary responsibilities.

The interest of the householder in the notification of the authorities is direct and immediate, since he needs what the doctor probably cannot give him if he would and probably would not if he could. Having both a private and a public interest in the notification of the health authorities, the householder should bear the penalty of failure to notify.

The popular prejudice against compulsory notification survives because

such ordinances are not enforced with respect to the minor infectious disorders. If householders were obliged to report mumps, whooping cough and measles, their experience with the milder affections would teach them that the law is both benevolent in intention and beneficient in action, so that in graver emergencies the intervention of the law would be, not suffered, but invoked.

In Rome the services of the public disinfectors are asked and obtained at short intervals during the progress of such a disease as tuberculosis.

The statutory provisions as to the time of reporting infectious disease should be stringently enforced. The report must follow the diagnosis immediately. In practice it is found that the report too often waits on the prognosis, and anticipates the death permit by such a breathless interval that one suspects there has not been a fair race between the shadow and the event. The weak point in most laws is the phrase "dangerous to public health," which is meant to include, within the meaning of the act, diseases not mentioned by name. In practice this descriptive phrase adds a third proposition essential to a conviction. It is possible to name all the diseases to which such an act should apply and conviction should follow proof of two propositions: First, that a disease named in the act existed at the time and place; and second, that it was not reported.

If it be true that complete statistics of non-infectious diseases are impossible of collection by law, I do not believe that the sanitarian is therefore obliged to pursue his work without the aid of such statistics. The scope of a statistical inquiry into disease is not defined by the nature of law, but by the community of interest among scientific men, and the degree of success or failure to collect such data is the precise measure of the scientific spirit. Experience shows that abundant data can be gathered upon any subject in which a number of people have a common interest. The now almost forgotten project of Louis by which a science of therapeutics was to have been built upon the collective study of symptoms failed, because the means were not related to the end, and in its failure demonstrated that the persistent interest of many men could be held by a common motive.

The late Benjamin Ward Richardson inaugurated a plan for the collection of sickness statistics, but in a short time the expense of preserving the observations became too burdensome for the body of contributors. The accumulated records, of great value, were offered to the government but were declined.

One general rule applies to all undertakings engaging the services of many men. The relations that are not mutually helpful are either hurtful or sterile. So that in order to collect statistics of sickness it is only necessary to convince a sufficient number of competent physicians that some adequate return will be made for contributions to such statistics. The best of our craft will not contend for fees in such work, but will be satisfied to know that the recorded and classified data will be of current use, or that the central office, which receives them, will return some sort of service.

The argument that a systematic record of all sickness would be too expensive is perhaps a good one. But perfectly reliable statistics of disease do not require reports of all sickness. If the returns of a competent corps of observers, say one hundred, well distributed over a given territory, reporting weekly, give results which are quite consistent from week to week, from month to month, and year after year, such statistics must be accepted under the law of probabilities as sound data. In Michigan, such a system of weekly reports has been practiced for twenty years and the records are of a surpassing value. One hundred observers sending weekly reports of the sickness occurring under their observation would put an instrument of precision into the hands of a central officer who should know how to handle those reports.

It is not only theoretically, but practically, true that a hundred representative physicians in active practice will each see whatever disease is pres-

ent in each locality and will certainly see, year in and year out, a fixed proportion of all the disease in the State.

That such reports can and do display in the aggregate the consistency and delicacy of instruments of precision is well illustrated by the chart which shows a wonderfully close relation between the average atmospheric temperature and the monthly reports of sickness from pneumonia in Michigan. These relations are so close that formulae may be derived from them which will enable one to compute within a very narrow margin of error the monthly pneumonia rate from the known average temperature.

It will thus be seen that in dealing with so large a subject as prevailing sickness it is no more necessary to have all the data of all observers, than one requires the readings of all the thermometers in Baltimore in order to determine the atmospheric temperature.

It is difficult for any man who is sensible of his own fallibility to realize that his observations with those of a number of equally fallible men will yield results of unvarying accuracy, but it is so. The combined records of a hundred sensible, honest men is a mine of many times the wisdom of any one wise man. It is out of the combination and not out of the addition or multiplication of observations that true results are accomplished and made evident. Truth is consistent and coherent, error inconsistent and incoherent. Hence as the mass of data grows the separation between truth and error grows ever clearer.

Records which are erroneous may still be useful, since few observations are false in toto, and even should the concrete error of a false classification be made, its falsity will one day appear and will be found capable of correction without disintegrating, perhaps without even dividing, the mass. Does any one wish that the statistics of croup had never been preserved, because they should have been charged to diphtheria, or that the statistics of typho-malarial fever were better lost than kept in the wrong pigeon-hole ?

I hope in the course of the meeting to show you illustrations of the easy recognition of false statistics and of the characteristic features of true tables, and that errors so neutralize each other as to have but little appreciable effect upon the total results of all statistics.

In conclusion, then, we have to say :

1. That compulsory notification of births, deaths and infectious diseases is a proper and important concern of the State and the worth of such records far outweighs the cost of obtaining them. Statistics of birth and death must be complete, because the State demands mathematical results.

2. That the collection of sickness statistics does not require and may be better effected without legislation. Their use being that of a sample for analysis, their value does not depend upon numerical completeness, but upon the fidelity of the observers. Such inquiry is a proper work of physicians and of the best physicians.

To the first proposition I have offered no proof that is new to, or needed by, any of you. Upon that we are agreed. To the second I invite your most serious consideration. If from this convention an impulse shall go forth which shall at length give Maryland an effective vital statistics law, it is well ; but if this assembly shall all realize the true worth of the daily observations of the feeblest man here and should exercise its ability to furnish a weekly list of the bare names of diseases present under each man's eye, such a work would give length of years to that which is now ephemeral.

Says Emerson : " The differences between men in natural endowment are insignificant in comparison with their common wealth. Do you think the porter and the cook have no anecdotes, no experiences, no wonders for you ? Everybody knows as much as the savant."

Let us besiege the shrine. The oracle will come and we shall discover how rich we are. To each man is the swift chance, but never too swift for all of us; to each experience is delusive, but all may see the serried facts ; to each is judgment difficult, but that which all affirm is so.

A CASE OF ENCYSTED DROPSY OF THE PERITONEUM.

SECONDARY TO UTERO-TUBAL TUBERCULOSIS AND PYO-COCCAL INFECTION, ASSOCIATED WITH TUBERCULAR PLEURISY, GENERALIZED TUBERCULOSIS AND PYO-COCCAL INFECTION.

By B. Bernard Browne, M. D.,
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READ BEFORE THE CLINICAL SOCIETY OF MARYLAND, JANUARY 15, 1897.

ENCYSTED dropsy of the peritoneum is an extremely rare pathological condition, which formerly was considered to occur more frequently in men than in women, but the progress of abdominal surgery during the past few years has contributed to our knowledge as to the origin of this condition and established the opinion that in all or nearly all cases it is due to tubercular peritonitis, which is much more frequent in females than was formerly supposed.

The fluid lies above or rather in front of the intestines, which are bound down by adhesions; it sometimes extends over the whole anterior aspect of the abdomen; sometimes being divided into several divisions or compartments, while in other cases it is confined by narrow limits. Depressions are sometimes felt on the surface corresponding to the dissepiments; this condition has been noticed by Peaslee. Fluctuation is weak and limited and does not change its relations on changing the position of the patient.

It does not, as a rule, interfere with respiration and digestion, like an ovarian cyst, nor is it attended by edema of the lower extremities, or enlargement of the abdominal veins.

These collections were described by Nuck as early as 1758 and were attributed by him to an effusion in the space between the peritoneal fold, which was supposed to be double. The researches of Bernutz in 1856 tend to include encysted dropsy of the peritoneum among cases of tubercular peritonitis encysted by adhesions. Bernutz compared all the cases of encysted dropsy of the peritoneum analyzed by Morgagni, as well as all those reported up to the date of his investigations, as examples of this form.

Bernutz, in 1856, in speaking of tubercular pelvic peritonitis, says: "It is somewhat surprising that this disease, which is far more common than is generally supposed, is not described in any of the modern treatises on gynecology. Tubercles may be deposited in any internal genital organ; sometimes only the ovaries are affected, in some cases the Fallopian tubes alone are diseased, as in the cases related, and, though the contrary opinion is generally entertained, I believe that the oviducts are more frequently affected than the ovaries themselves; and that whenever the uterus is tubercular, the oviducts are sure to be so."

In 1885, Dr. Wm. T. Howard of Baltimore gave as his address as President of the American Gynecological Society a paper entitled "Two Rare Cases in Abdominal Surgery." In this paper he treated the subject of encysted dropsy of the peritoneum in a very thorough manner and referred to several most interesting cases, among them that of Gardner of Montreal. (*Canada Medical and Surgical Journal*, June, 1885.) This case is also reported in full in the more recent paper of Dr. Osler in the Johns Hopkins Hospital Reports, 1890.

Dr. Howard went very fully into the differential diagnosis of encysted dropsy of the peritoneum from other forms of abdominal tumors.

His second case, at which he kindly invited me to be present, was in July, 1883; the patient was Francis R., aged 24. She seemed to belong to the white race, from her fair, white skin, long, straight auburn hair and somewhat ruddy cheeks. But it was subsequently

ascertained from the visits of her associates that she claimed to be of the colored race. The similarity in appearance led me to believe that this was encysted dropsy of the peritoneum. When he cut down to the peritoneum, he found it very much thickened; he introduced the trocar and drew off about 40 pints of slightly viscid greenish fluid; when this was removed one could look into an immense unilocular cyst, which seemed to occupy the entire abdominal cavity and to be tightly stretched over the spinal column and even the pelvic brim, down nearly to the ileo-pectineal line. It appeared as if all the intra-abdominal organs had been removed, excepting that there were no signs of where they had been attached.

In the paper above referred to, Dr. Osler has classified the tumor formations in tubercular peritonitis in four groups :

1. Omental tumor.
2. Sacculated exudations.
3. Retracted and thickened intestinal coils.
4. Mesenteric glands.

The cases under consideration in this paper are those of the second group.

The following case is reported in "Meigs' Diseases of Women :"

"A few years ago I opened the body of an elderly woman who died with an immense collection of water in her abdomen. The fluid amounted to many gallons, and, after it had been removed, I continued the incision from the sternum to the pubis ; and when I had finished the incision and looked into the cavity I was for some time very much astonished to behold only a smooth muco-serous surface in the cavity and looked for some time in vain to find any liver, or stomach, or alimentary canal.

"It seemed as if I was examining an abdomen from which all the viscera had been carefully removed. I was greatly astonished and quite at a loss what to think of the case, or imagine what had become of the abdominal viscera, since the line of the spinal column was strongly drawn at the back of the great cavity I was inspecting and I seemed to look quite up into the empty concave of the diaphragm."

DIFFERENTIAL DIAGNOSIS OF ENCYSTED DROPSY AND OVARIAN CYST.

ENCYSTED DROPSY.	OVARIAN CYST. THIRD STAGE.
Is extremely rare. Slow increase. Preceded by an attack of peritonitis.	Common, and grows rapidly. Preceded by good health.
Features natural.	Features peculiar.
Health not bad. No dyspnea unless pleurisy exists. Digestion good.	Health impaired. Dyspnea. Digestion poor.
Abdomen not prominent at points, even depressed.	Everywhere prominent.
Abdominal veins not enlarged nor lower extremities edematous.	Abdominal veins enlarged. Extremities frequently edematous.
Fluctuation not strong, limited in extent, fluid being in front of the intestines.	Fluctuation decided, Intestines on sides of the cyst.
Pleurisy frequent.	Pleurisy seldom.
Per vaginam.	Per vaginam.
Uterus in normal place, sometimes fixed by adhesions, a mass or tumor felt on one or the other side of the uterus.	Uterus generally behind the tumor, which is in the median line, and fluctuation can be detected.
Sputum sometimes contains tubercle bacilli.	Sputum negative.
Temperature, 101° to 103°, P. M. Frequently subnormal in morning.	About normal.
Age, 24 to 30.	All ages.
Race, mulatto or colored.	Generally in the white.

The case which I wish to report is the following :

Narcissa Allen, a whitish mulatto women aged 30, entered the Good Samaritan Hospital, November 7, 1895. She was married and had one child about one year previously. She had commenced to menstruate at 15, had very much pain, and the flow had always been very free and lasted from six to eight days.

Her general health had always been fairly good. She had measles about the time she was grown, and an attack ot malarial fever five years ago, lasting about three months. She had never been conscious of having any tumor or swelling until the fifth month of her pregnancy, when she noticed a hard lump on the left side which caused her intense pains at the time; she thought it disappeared, but a short time before her confinement she noticed a similar swelling on the right side but lower down in the abdomen; this swelling continued in the same position until she entered the hospital.

After the birth of her child she did not menstruate, but for months after-

wards she thought she was pregnant; the abdomen enlarged and the tumor on the right side increased in size until August, from which time until November 7; when she entered the hospital her condition remained about the same except she became weaker and emaciated.

On November 10, she was examined under an anesthetic and a hard, irregular tumor about four inches long and three in diameter was found on the right side and appeared to be connected with the uterus by a broad attachment. The woman seemed so weak and emaciated that it was deemed advisable not to attempt the removal of the tumor until her condition improved.

On the 13th, her abdomen commenced to swell and a general peritonitis set in; her temperature varied from 100° to 103° in the evening and frequently became subnormal in the morning. She had a cough and expectorated a great deal. As there was every reason to believe her condition was tubercular her sputum was examined on several occasions, but with negative results.

She grew weaker and suffered so much from the abdominal distention that on February 27 an incision was made in the abdomen and the fluid removed. Upon cutting down to the peritoneum it was found to be very much thickened and when cut through about three gallons of a thin, greenish fluid escaped.

The empty sac extended from the diaphragm above almost to the symphysis, the intestines and other abdominal organs were completely shut off by the exudate, and none of them came into view.

On the right side where the tumor was situated was another partially shut off sac which contained about a pint of semi-solid, cheesy substance, which was removed.

The report by Dr. Claribel Cone of the microscopic examination of this fluid showed numerous pus cells, some red blood corpuscles and shreds of necrotic tissue entangling pus cells. Stained coverslip preparations exhibited numerous cocci in pairs, clusters and short chains; but no tubercle bacilli were found.

After the removal of the fluid the patient was very much more comfortable and improved for about a week, when she died very suddenly.

The post-mortem examination was made by Dr. Cone, Professor of Pathology in the Woman's Medical College, and Pathologist to the Good Samaritan Hospital.

(Extracts from the Report of Dr. Cone will be published in a future number of the JOURNAL.)

THE DANGERS OF ARTIFICIAL TEETH.

AN inquest reported in the *Lancet* was held at St. Bartholomew's Hospital with reference to the death of a patient from hemorrhage caused by an artificial denture which had been swallowed some eight or nine months previously during a fainting fit. The patient was at the time seen by a medical man who, being unable to remove the denture by the mouth, forced it down towards the stomach, presumably with the hope that it would be passed per rectum. Death from swallowing artificial teeth is more common than is generally supposed, and many cases are to be found recorded in the various journals devoted to dental practice. Artificial teeth properly fitted and secured are in themselves quite free from danger, and it is only when people persist in wearing small, loosely fitting dentures that trouble is likely to arise, as a fit of coughing or fainting or even drinking may dislodge them and so allow them to be swallowed. Should such an accident occur prompt treatment is necessary and if it is found impossible to remove the denture by the mouth or it fails to pass per rectum esophagotomy or gastrostomy should be performed, for if the plate be allowed to remain ulceration and hemorrhage are certain sooner or later to supervene, leading invariably to a fatal result.

THE TREATMENT OF ACUTE LOBAR PNEUMONIA.

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Richmond, Va.,

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READ BEFORE THE RICHMOND ACADEMY OF MEDICINE AND SURGERY, FEBRUARY 9, 1897.

Prognosis. — Osler makes the statement, in his classical work, that "Pneumonia is one of the most fatal of acute diseases. Hospital statistics show that the mortality ranges from 20 to 40 per cent. Of 1012 cases treated in the Montreal General Hospital, the mortality was 20.4 per cent. It appears to be somewhat more fatal in southern climates. Statistics from the Charity Hospital, New Orleans, show the death-rate to be 28.01 per cent. It has been urged that the mortality in this disease has been steadily increasing, and attempts have been made to connect this increase with the expectant plan of treatment, but careful analysis of 1000 cases by Townsend, in the Massachusetts General Hospital, indicates clearly that when all circumstances are taken into consideration, the conclusion is not justified. He found that when all fatal cases over fifty years of age were omitted and those patients who were delicate, intemperate, or the subject of some complication, there was very little variation from decade to decade and that, excluding these cases, the rate was little over ten per cent. In answer to the assertion that the modified treatment is in part responsible for the increased mortality, he shows clearly that the rise in death-rate took place in the period prior to 1860, when the treatment was entirely or in great part heroic."

In a short interview with a prominent member of the profession, he made the statement to me that in a discussion of the mortality of acute pneumonia with Dr. Hunter McGuire, their experience with this disease was similar. They had never known a young adult, whose previous history was good, to die with pneumonia. A careful study of my notes of cases shows that, while I have treated a good many cases, in healthy young adults, my limited experience has been the same as theirs.

Diagnosis. — "No disease is more readily recognized in a large majority of cases. The external character, the sputa and the physical signs combine to make one of the clearest of clinical pictures."—*Osler.* Dr. Osler says: "After a study, in the post-mortem room, of my own and others' mistakes, I think that the ordinary lobar pneumonia of adults is rarely overlooked. Judging from my autopsy records, I should say that errors are particularly liable to occur in the intercurrent pneumonias, in those complicating chronic affections and in the disease as met in children, the aged and drunkards. Pleurisy with effusion is, I believe, not often mistaken, except in children."

Treatment. — Wood and Fitz: "In the treatment of pneumonia, it is essential to recognize that, though the disease may be a unit from the pathological point of view, therapeutically it comprises essentially diverse diseases. A pneumonia whose physical signs can not be made out in the beginning, but gradually creep up towards the chest wall, a pneumonia whose expectoration is in the beginning prune juice, whose crepitant râle is never typical, whose physical signs are obscure until complete consolidation gives percussion dulness, or a pneumonia occurring in the alcoholic, in the old, in the victim of renal disease, in the broken-down debauchee, is, in its management, essentially distinct from a pneumonia the result of exposure of a strong, healthy countryman to a Western blizzard or other cold." "When, in the first twenty-four hours of a pneumonia, there is violent constitutional reaction, with flushed face, rapid and noisy breathing,

bloody sputa, intense headache and drowsiness, a hard, bounding, or a tense, corded pulse, venesection may markedly lessen all the symptoms, and, if combined with dry cupping over the whole chest, may, we believe, lessen the amount of engorgement of the lung and the final area of consolidation." Wet compresses, and even the application of the ice-bag very freely over the affected lung, are recommended by some of the leading text-books and authorities; and just at present the ice treatment is quite a fad at the North. At the very beginning of an attack, where active congestion is just begun, ice might prove of service, as it is of value in any other form of active congestion; but, even then, it should be, it seems to me, used with the greatest caution, if at all, because of the shock, more or less, and the causes calling for its indication should have to be very carefully selected. Personally, I have had no experience with it and shall certainly not use it, till I am fully convinced that the after-effects are not worse than the remedy. "The question how far we should attempt to reduce temperature is important in the extreme and is answered very differently in practice by different practitioners." Although a great many authorities advise against the use of any of the coal-tar class, my experience does not agree with their statement. When the temperature is 103°-4°, I use, frequently, five-grain doses of phenacetine, repeated at regular intervals, until the fever is reduced to 100° or so, and never, as yet, have I seen any but the best results follow its administration. Quinine, it used, has to be employed in large doses and rather does harm than good, because of the resulting nervous excitation. I prefer the bisulphate or muriate.

"To prevent exhaustion, by maintaining the forces of the patient, is the great object of the nursing in pneumonia. Absolute confinement in bed from the beginning, regulating the temperature of room 70° to 74°, feeding at regular intervals (two or three hours),—food should be simple, nutritious and digestible; milk, animal broths, clam broth is very acceptable." "Alcohol in the beginning of sthenic pneumonia is injurious. In the advanced stages of the disease, it being regarded therapeutically as allied to an infectious fever, it of service, employed judiciously." "In the advanced stages of a severe pneumonia, tinct. digitalis, 5 to 15 minims at intervals of four to six hours, acts well as a heart stimulant. Its effects upon the pulse should be the guide for administering."

Nitro-glycerine and amyl nitrite should be used with caution in sufficient doses to produce effects. They always lower the arterial pressure by depressing directly the muscle fibers in the blood-vessel's walls, and although their first action upon the heart is a stimulant, the slightest overdose converts such action into that of a powerful depressant. Carbonate of ammonium is very largely used, both as a stimulant and as an expectorant." Some authorities, among them one that I quote from very freely — Wood and Fitz — say, "there in no reason for believing that it has any effect on the consolidated lung, and that its power as a stimulant is certainly inferior." I must enter my humble protest against these assertions, for in several hundred cases of this disease I have treated in hospital and general practice, I can candidly say that I have found this drug of the utmost service, both as an expectorant and stimulant. My dosage is also at variance with theirs. They advise three grains or so; I employ five to ten grains, as indicated in the individual case.

Aromatic spirits of ammonia is also valuable as a cardiac stimulant when needed. The most important drug, in my hands, as a respiratory and circulating stimulant, is strychnine. "The special indication for the free use of this agent is cyanosis, with hurried breathing and other evidences of respiratory distress. For relief of local pain, dry cups probably give quickest relief."

Blisters, the greatest single agent in treating this disease, have saved more lives than all the drugs in the materia medica. If used skilfully and when indicated, that is, in the beginning of the

third stage, they will afford prompt relief from pain, aid the expectoration of the clogged lung, and very materially hasten convalescence.

In conclusion, allow me, from the limited time assigned me, to entirely disclaim originality for this paper. The great mass of it is quoted from authorities — Osler and Wood and Fitz. I have given them due credit for all their quotations, which are taken literally and liberally from their works.

Medical Progress.

The Causation of Sex.—The determining factor in sex, says the *Lancet*, has always been the subject of controversy, but up to the present time, although numerous theories have been propounded, none can be deemed satisfactory and the causation of sex is still as much shrouded in mystery as is biogenesis. Perhaps one reason why so little progress has been made in the elucidation of this profound problem is the fact that there are so few opportunities of ascertaining reliable facts relating to the human subject in this connection. Be this as it may, there can be no doubt that experiments on animals with a view to clearing away the mist with which this question is obscured would greatly add to our knowledge of the subject and if the controversy which is taking place in the columns of our contemporary, the *Stock-keeper*, should have this effect not a little good may result. The theories which up to the present have been propounded are well known to readers of the *Lancet*, in the columns of which several attempts have been made to thresh out the subject; but a letter from Mr. J. F. Chambers in the issue of the *Stock-keeper* of January 8, in which he ably propounds what may be called the katabolic and anabolic theory, will be read with interest. He says the fetus passes through three cycles: (1) sexless; (2) hermaphrodite or bisexual; and (3) unisexual; and argues that at the second stage the "breeder may step in and enjoin nature to proceed after his wishes."

A Method of Treating Acute Dysentery.—In the *Therapeutic Gazette*, the following method, employed by Testevin, is mentioned. The objects which we seek in the treatment of this condition are, to diminish the number of the stools, to antisepticize and modify the intestinal secretions, to attack the local anatomical lesion, and to abate collapse.

The best method of decreasing the number of the stools is by the hypodermic injection of morphine $\frac{1}{12}$ grain, given every hour. At the same time, in the intervals between the injections the abdomen of the patient should be covered by a large mustard poultice, which will act as a revulsive and relieve the pain. In other instances an equally good result can be obtained by the use of a rubber ice bag applied over the abdomen. Intestinal antisepsis is best realized by the administration of calomel in frequently repeated small doses for two or three days, and it is often well to associate with it ipecac and opium. As soon as the stools are bilious in appearance this medication can be stopped and full doses of bismuth can be administered.

* * *

Widal's Typhoid Test. — Comba (*British Medical Journal*) furnishes confirmatory evidences of the value of this test in thirteen cases reported by him. In every case of typhoid the reaction was positive; in other diseases it was negative. In the early days of the disease the reaction may fail. It is present during convalescence, although rather less marked. The bacillus coli gives a similar reaction, but much less marked, indeed not more than may be observed in patients affected with other infectious diseases. Each of the thirteen cases is more or less fully recorded.

* * *

Vomiting in Tuberculosis.—Barth prescribes, in the *Therapeutic Gazette*, for the vomiting of tuberculous patients, a wineglassful of vichy water after each repast, which should be light and simple. After meals he gives a cachet of prepared chalk, magnesia, binoxide of manganese and belladonna; opium may be added if necessary.

MARYLAND

Medical Journal.

PUBLISHED WEEKLY.

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MARYLAND MEDICAL JOURNAL,
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BALTIMORE, FEBRUARY 27, 1897.

PREMONITIONS of a new spirit of progress in Maryland, of a quickening in the old life of civic and professional institutions, have of late years been brought to the attention of every intelligent medical man through the columns of the daily press and of this JOURNAL.

The Conference of Health Officers.

To the aid of those physicians who, loyal to their profession, have long striven, amid great discouragements, for its enlightenment and unification have gradually come of late many unexpected reinforcements. Successful city and State political reform movements, the quiet but powerful influence of the two branches of the Johns Hopkins University, the higher standards of medical education initiated by the older colleges at the suggestion of a modest city practitioner, the influx of well-trained young physicians from other States, the generosity of members of the Medical and Chirurgical Faculty and of the Messrs. Frick, have all contributed to bring the new era. Thence has sprung the new sanitary movement embodied in the recent Conference of Health Officers. A few years ago it would have been but an aimless spurt; coming at the present juncture it is the beginning of a well-secured advance which will end in setting our State in the front ranks of sanitary excellence.

The reports to be given in this JOURNAL will reveal the value and scope of the work done. The conference met in the hall of the Medical and Chirurgical Faculty and was attended by large numbers of city and county physicians in addition to those specially delegated to it. The papers and demonstrations were every one worthy of the occasion, eliciting very lively discussions. It is evident that the county health officers are picked men in their communities.

Throughout the conference a spirit of fairness and desire for public improvement was evinced, and it is evident that the State Board has the coöperation of a very loyal corps of workers in its new measure. The Legislature will do well to heed the varied suggestions of the conference and consider well the bills concerning control of water and milk supplies, abatement of nuisances, regulation of burials, etc., which will be prepared by the Conference Committee.

Legislatures nowadays have timid souls, very fearful lest their laws should not be based on strong public opinion; therefore, our readers can aid greatly in the good work by noting carefully the improvements which the conference has deemed necessary, and bringing these needs to the attention of citizens and patients in their districts. When the Legislature meets, opportunity will doubtless be given for bringing direct pressure to bear upon the legislators.

Meantime it is to be hoped that the local sanitary officers of the counties, who have shown such interest in these public advances, will be encouraged by more earnest sympathy and coöperation from those practitioners who live near them. There ought never to arise any serious variance between intelligent health officers and public-spirited physicians concerning the need of sanitary improvements.

Kindly recognition should be given to the energy shown by the present Secretary of the State Board of Health; and a hearty welcome extended to the new-born Maryland Public Health Association.

President Gilman, of the Johns Hopkins University, was right when he publicly de-

clared the recent health conference to be "The most hopeful sign of progress seen in Maryland in twenty years — and one full of promise to all classes of the community."

* * *

Experimental Medicine.

The advances in medical science have been manifold and on all sides is progress noted, but especially in the department of experimental medicine has work been active and great interest has been taken in experimental work in the domain of pathology, pharmacology and physiology.

These have in part appeared to the profession in journals devoted to the especial branches of pathology, pharmacology and physiology, but in America, at least, there has been wanting up to a year ago a journal in which could be recorded the results of the immense amount of experimental work which has been done in such large schools as Harvard, Columbia, Ann Arbor, the Johns Hopkins and others.

The *Journal of Experimental Medicine*, which was established about a year ago under the auspices of the Johns Hopkins University, has just completed its first year and enters on its second with a feeling of great gratification and encouragement. As is stated in an introductory note by the editor, Dr. William H. Welch, "The purposes of this journal have already been realized in a great measure. The high character of the journal, the good quality of the typography, the abundance and general excellence of its illustrations, the absence of extraneous matter and its circulation at home and abroad have rendered it an especially suitable medium for the publication of papers embodying original research in the various departments of medicine presented in its pages."

The life of this journal for one year has demonstrated beyond the shadow of a doubt that not only is there an abundance of good scientific work done in America in medicine by American investigators, but that there are not a few subscribers who can appreciate such good work. While this journal appears under the wing of the Johns Hopkins University, it is by no means a local publication, as the list of editors and collaborators will show, and hence any words of praise and encouragement are meant not only for the progressive men who put their hands deep down into their own pockets and undertook this great work, but for the many workers and contributors on it throughout this great land.

It is, therefore, fitting to say that while more subscribers have been obtained than was originally hoped for, the enterprise is by no means self-supporting, nor is is it intended to be a money-making scheme, for the publication of such a journal involves many expenditures not covered by the subscriptions received.

The editor, therefore, makes a patriotic appeal to the profession at large and men not only scientific in the sense of practical workers, but intelligent readers who have been denied the pleasures and profits of laboratory work, but who take an intelligent interest in medical progress, should make it a point to take the *Journal of Experimental Medicine* and not only profit by the matter contained therein, but have the patriotic feeling that they are contributing towards the support of an American journal that stands inferior to none and superior to most.

* * *

Emulsions.

Emulsions are usually associated in the mind with cod liver oil and are generally prescribed as the most palatable and easily digestible form in which to give this nauseous medicine. Dr. John F. Russell, in the *New York Medical Journal*, believes in emulsions but thinks they are as a rule badly made and contain too much inert and waste material. He believes instead of using mucilage and such substances to finely divide the oil globules, in imitating nature by using pancreatic juice. Emulsions made in this way contain more oil than ordinary emulsions and are not acted on by the gastric juice.

There is no doubt but that oil is not readily digestible and palatable even to the normal healthy organism and when it is poured into a diseased body in such large quantities, the results can hardly be salutary. Pure cod liver oil is generally given in too large doses, while in the ordinary emulsion much inert and foreign matter is introduced into the system.

An examination of the various emulsions under the microscope will show how finely subdivided the oil globules are and how assimilable such products are. Physicians should not take too much on faith, but occasionally make tests of their own.

Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending February 20, 1897.

Diseases.	Cases Reported	Deaths.
Smallpox		
Pneumonia		31
Phthisis Pulmonalis		24
Measles	1	
Whooping Cough	3	1
Pseudo-membranous Croup and Diphtheria.	20	6
Mumps	7	
Scarlet fever	21	2
Varioloid		
Varicella	2	
Typhoid fever	7	1

Dr. E. T. Ellis of Richmond, Virginia, died in that city last Monday.

Dr. E. T. Getzendanner died at his home near Poolesville, Md., last Saturday, aged 73.

The new dead-house of the University of Maryland has been completed.

Dr. Michael A. Durdey, a retired physician of Cecil County, died last Saturday, aged eighty years.

In 1880, America had 183 medical journals and in 1895, 367, of which 343 were published in the United States.

About $1700 was netted from the charity performance for the benefit of the University of Maryland Hospital.

Health Commissioner McShane has found more diseased cows in Baltimore and vicinity and has stopped the sale of milk from them.

Dr. William E. Moseley has a private gynecological hospital connected with his office, southwest corner of Howard and Madison Streets.

Baroness Hirsch is contemplating the desirability of giving 2,000 000 francs ($400,000) for the erection of a hospital on the Riviera for consumptive children.

According to the *Bulletin of the American Academy of Medicine*, the only medical schools in Baltimore receiving official recognition in Connecticut are the Johns Hopkins Medical School and the Woman's Medical College.

The State Live Stock Sanitary Board met recently and formulated plans to employ a number of inspectors to stamp out tuberculosis in cattle in the State.

Sir Spencer Wells, past President of the Royal College of Surgeons, London, died recently, aged 78 years. He is principally known in this country in connection with his work on the ovary.

At the last meeting of the Philadelphia Neurological Society on January 25, 1897, Dr. Lewellys F. Barker read a paper entitled "Flechsig's Association Centers in the Cerebral Cortex."

Dr. William S. Thayer, Associate Professor of Medicine in Johns Hopkins University, Baltimore, will address the tenth quarterly special meeting of the Cleveland Medical Society on March 26.

The death is announced of Dr. Hugh Jenkins Prichard of Baltimore, son of Dr. J. E. Prichard. The deceased died on his twenty-eighth birthday. He studied at the College of Physicians and Surgeons and also the Baltimore University School of Medicine.

Dr. Irving C. Rosse of 825 Vermont Avenue, Washington, D. C., is so convinced that there is no such disease as hydrophobia that he has offered, over his own signature, a reward of $100, in the interest of science, to anyone producing a well-authenticated case of that disease in man or dog.

The Baltimore Eye, Ear and Throat Charity Hospital will soon have a large new building next door to its present building on West Franklin Street, Baltimore. The hospital was established in 1882 and has prospered under the charge of Drs. Russell Murdoch, Samuel Theobald and H. Clinton McSherry.

Dr. E. N. Brush has made his annual report of the Sheppard Asylum for 1896. There were under his care at the end of the year 46 men and 33 women, a total of 79. Of those discharged, 17 had recovered, 12 were much improved, 23 were improved, 10 were unimproved and 9 had died. This report would make a still better showing if friends of the patients had not removed them injudiciously before the end of the treatment. This closes the work of the first five years of the institution and shows what excellent work has been done under the efficient guidance of Dr. Brush's skilled supervision.

Book Reviews.

SWEDISH MOVEMENTS OR MEDICAL GYMNASTICS. By Dr. T. J. Hartelius. Translated by A. B. Olsen, M. D., with introduction and notes by J. H. Kellogg, M. D. 162 pp. Price $1.50. Modern Medicine Publishing Co., Battle Creek, Michigan.

This book offers to the layman and teacher of gymnastics a long needed manual of exercises that can be given without the use of apparatus. It does not, however, meet the requirements of the practicing physician, who needs a work that discusses the human body from the physiological and pathological standpoint and which treats fully of the therapeutic effects of massage and exercise, with and without the use of apparatus. Still it is worthy of careful perusal by those interested in the subject. While reading the descriptions of the exercises, it is necessary to keep constantly before the mind the applied anatomy and the mechanism of the parts under discussion, in order to be able to fully understand the remote as well as the direct effects of the movements. It is to be regretted that the translator did not take greater liberties with the text, which would have enabled him to use terms that are technically correct rather than the incorrect literal translations. The work (while by no means free from error and demanding caution in the use of the prescriptions given) is a step, and a long step, in the right direction and Dr. Olsen deserves the gratitude of his co-laborers for performing a task which, at its best, is apt to be a thankless one. We would welcome an exhaustive textbook on Medical Gymnastics discussing its mechanism and therapeutics, along with the physiology, pathology and anatomy involved.

A TEXT-BOOK OF DISEASES OF THE NOSE AND THROAT. By Francke Huntingdon Bosworth, A.B., Cantab., A.M., M.D., Professor of Diseases of the Throat in Bellevue Hospital Medical College, New York, etc. Illustrated with 186 Engravings, New York. William Wood & Co. 1896. Pp. 814.

This is a condensation and revision of the author's work which appeared several years ago. The book has been thoroughly reviewed and brought up to date. It is divided into three sections. Section I is on Diseases of the Nasal Passages; Section II on Diseases of the Naso-Pharynx; and Section III on External Surgery of the Nose.

THE PHYSICIAN'S VEST-POCKET FORMULA BOOK, published by McKesson & Robbins, will be found very useful to the practitioner. It contains a table of weights and measures, antidotes to poisons, various tables of reference and a very complete series of tables, showing the composition of foods and alcoholic liquors. These tables should prove valuable to the physician in cases where special attention to dietary is necessary. The book also contains an extended series of notes on some of the new pharmaceutical preparations and a complete list of formulae of the McKesson & Robbins Gelatine Coated Pills. A copy will be sent free of charge to any of our readers on application to McKesson & Robbins, 91 Fulton Street, New York.

THE LARYNGOSCOPE, published in St. Louis, has been selected as the official organ, for the year 1897, of the Laryngological Section of the New York Academy of Medicine. This selection, and the great probability of the same journal being chosen by other laryngological, rhinological and otological societies as their official organ, would indicate that the *Laryngoscope* has become what its proprietors stated they intended to make it, *i. e.*, The American Journal of Record for the specialties represented.

REPRINTS, ETC., RECEIVED.

Vegetable Dyspepsia. By W. A. Walker, M. D. Reprint from the *Therapeutic Gazette*.

Special Report of the Kensington Hospital for Women from its Organization in 1883 until 1896.

Pediatrics, Past, Present and Prospective. By S. W. Kelly, M. D. Reprint from the *Cleveland Medical Gazette*.

Remarks on the Cause of Glaucoma. By Leartus Connor, A. M., M. D. Reprint from the *Journal of the American Medical Association*.

The Solvent Properties of the Buffalo Lithia Waters of Virginia. By George Halstead Boylan, M. D. Reprint from the *New York Medical Journal*.

A Series of Articles on Speech-Defects as Localizing Symptoms, from a Study of Six Cases of Aphasia. By J. T. Eskridge, M. D., Denver, Colorado. Reprint from the *Medical News*.

PROGRESS IN MEDICAL SCIENCE.

"HAVING derived material benefit from the use of Tongaline during several years past, I feel it no less a duty than a pleasure to make the following statement in regard to it. All of the ingredients contained in this preparation have been demonstrated as especially valuable in neuralgia, rheumatism, gout and sciatica and the compound by recent observers has been noted as quite beneficial in relieving the pains incident to la grippe as well as nervous headache. Having made quite frequent use of it, as before stated, with most satisfactory results in some cases of acute rheumatism, in many of chronic and muscular, as well as neuralgic, affections, I have no hesitation in earnestly recommending it in similar cases and I know that in many cases of these affections I have saved my patients from the dangerous necessity of a resort to opium or its salts. Many other observers speak in most high terms of it after thorough and repeated trial."—DEERING J. ROBERTS, M. D. Extract from *Southern Practitioner*.

LARYNGEAL OR WINTER COUGHS.—Walter M. Fleming, A. M., M. D., Examiner in Lunacy, Superior Court, City of New York; Physician to Actor's Fund of America, etc., in giving his experience in the treatment of the above and allied disturbances, in the *Journal of Nervous and Mental Disease*, submits the following: "In acute attacks of laryngeal or winter cough, tickling and irritability of larynx, faith in Antikamnia and Codeine Tablets will be well founded. If the irritation or spasm prevails at night the patient should take a five-grain tablet an hour before retiring and repeat hourly until allayed. This will be found almost invariably a sovereign remedy. After taking the second or third tablet the cough is usually under control, at least for that paroxysm and for the night. Should the irritation prevail morning or mid-day, the same course of administration should be observed until subdued. In neuroses, neurasthenia, hemicrania, hysteria, neuralgia and, in short, the multitude of nervous ailments, I doubt if there is another remedial agent in therapeutics as reliable, serviceable and satisfactory; and this, without establishing an exaction, requirement or habit in the system like morphine.

NOTES ON THE TREATMENT OF FECAL FISTULAE.—At the thirteenth annual meeting of the New York State Medical Association, which was recently held in New York City, Dr. Frederick Holme Wiggin of New York county presented a paper with the above title. The chief cause of the occurrence of fecal fistula was stated to be the delay in resorting to operative measures to which patients suffering from typhlenteritis, or strangulated hernia, were frequently subjected while their ailment was carefully diagnosticated. The view recently advanced by a writer on the subject under consideration, that the best treatment for this condition consisted in its prevention, was concurred in. But in the case in which this mishap had occurred, it was pointed out that if the opening was of small size, was located near or below the ileo-cecal valve and no obstruction to the fecal current existed, operative measures might be deferred, as in most instances the opening would close in a short time spontaneously. On the other hand, if the bowel opening was of large size, was situated laterally, or some distance above the ileo-cecal valve, and was accompanied by the escape of a large proportion of the contents of the bowel, operative procedure for the closure of the opening should be speedily undertaken. The histories of three cases, successfully treated by surgical measures, were cited. In describing the technique employed, the writer laid much stress upon the following points, viz.: the thorough disinfection of the parts, including the interior of the bowel, with hydrozone, the closing of the intestinal opening, when possible, before the breaking up of the peritoneal adhesions, and the opening of the general cavity, the removal of any existing obstruction to the fecal current, the disinfection of the bowel surface with a solution of hydrozone, before and after the placing of the sutures, the control of oozing from the cicatricial tissue by the same means and the closure by a single row of silk-worm gut sutures without drainage of the abdominal wound after the washing of the peritoneal cavity with saline solution, some of which is allowed to remain.— Abstract from *Medical Record*, October 24, 1896.

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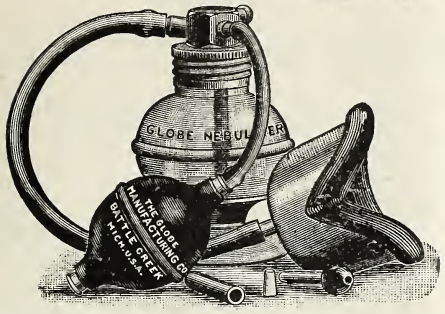

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Current Editorial Comment.

COMMON DISEASES.

Atlantic Medical Weekly.

NOT infrequently our desire to do original work leads us to study the rarer forms of disease and our discussion, although the result of painstaking study, finds but few readers who are interested in that particular subject, while the commoner types of disease are passed over as unworthy our attention.

TOO MANY PHYSICIANS.

Lancet.

IT is obvious that there is a rush into the profession far beyond what is necessary to supply the public with medical assistance or the members of the profession with such employment as will recoup them for years of laborious study. It is noticeable that London has twice as many practitioners (1 in 850) as the provinces. But the place which is blessed with the largest proportion of medical men to population is the Scotch metropolis. Edinburgh has 1 practitioner to 500 people. Dublin comes next with 1 to 600. It would seem as if in these places the activity of medical education and the number of medical schools in proportion to the population had an effect of drawing or detaining practitioners, many of them depending as largely on teaching as on practice.

CONSULTANTS.

Medical and Surgical Reporter.

IT is neither necessary nor always desirable to call upon the man with the highest popular reputation. Men of such reputation will sometimes be found who will not devote the time to a case which it deserves, but will make a snap diagnosis and advise treatment from a crude understanding of the case. Our own custom has been, without sacrificing the interests of the patient, to run counter to the natural tendency of giving to him that hath, and to call in consultation men who appreciate the professional support thus given, rather than those who appear to consider it a condescension to meet a fellow practitioner at the bedside of a patient. *Per contra*, it must be distinctly understood that the choice of a consultant does not require a *quid pro quo*, and that a return in kind or in other ways is not to be expected.

Publishers' Department.

Society Meetings.

BALTIMORE.

BALTIMORE MEDICAL ASSOCIATION, 847 N. Eutaw St. Meets 2d and 4th Mondays of each month.

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THE JOHNS HOPKINS HOSPITAL MEDICAL SOCIETY. Meets 1st and 3d Mondays, 8 P.M.

THE JOHNS HOPKINS HOSPITAL JOURNAL CLUB. Meets 4th Monday, at 8.15 P. M.

MEDICAL SOCIETY OF WOMAN'S MEDICAL COLLEGE. SUE RADCLIFF, M. D., President. LOUISE ERICH, M. D., Corresponding Secretary. Meets 1st Tuesday in the Month.

UNIVERSITY OF MARYLAND MEDICAL SOCIETY. Meets 3d Tuesday in each month, 8.30 P. M. HIRAM WOODS, JR., M. D., President, dent. E. E. GIBBONS, M. D., Secretary.

WASHINGTON.

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MEDICAL ASSOCIATION OF THE DISTRICT OF COLUMBIA. Meets Georgetown University Law Building 1st Tuesday in April and October. W. P. CARR, M. D., President. J. R. WELLINGTON, M. D., Secretary.

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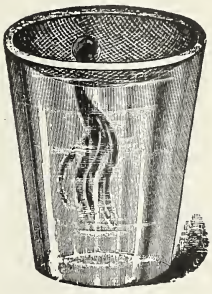

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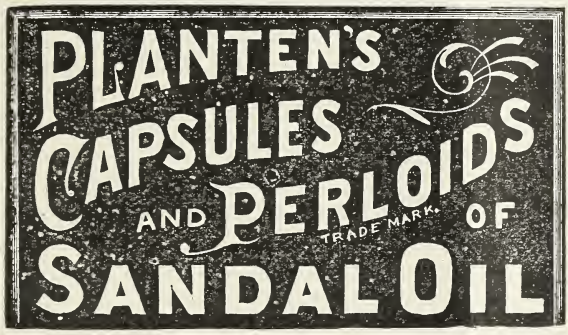

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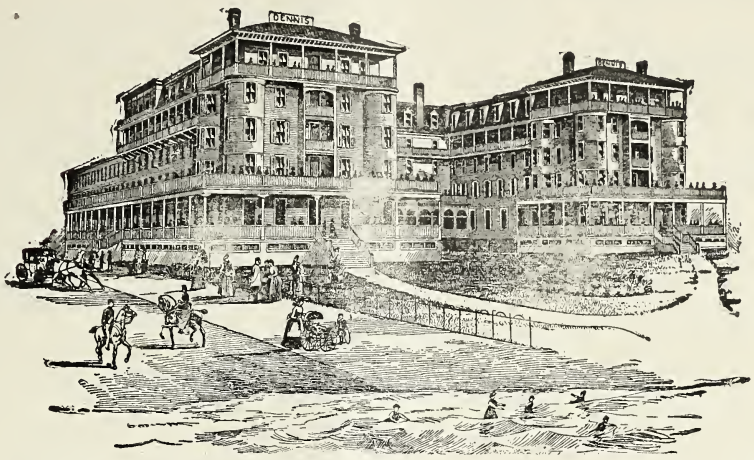

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NOTICE—CAUTION.

The Success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, *finds that no two of them are identical*, and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen when exposed to light or heat, *in the property of retaining the strychnine in solution*, and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing the Syrup, to write "Syr. Hypophos. *Fellows.*"

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear, can then be examined, and the genuineness—or othetwise—of the contents thereby proved.

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